

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. _____

14160

FILED APR 16 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1765</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>51</u> years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		3.188	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2808 East 11th Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u>		b. (Middle) <u>J</u>		c. (Last) <u>FAHEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 26 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 7 1884</u>		9. AGE (In years last birthday) <u>68</u> # UNDER 1 YEAR Months Days # UNDER 1 MIN. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Captain—K. C. Fire</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Galway, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>4</u>	
13a. FATHER'S NAME <u>JOHN MICHAEL FAHEY</u>		13b. MOTHER'S MAIDEN NAME <u>MARY CONNOR</u>		14. NAME OF HUSBAND OR WIFE <u>Eda M. Fahey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Eda M. Fahey 2808 East 11th St</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral artery of sigmoid</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u> <u>3 hrs</u> <u>153X</u>	
19a. DATE OF OPERATION <u>Mar 18 53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cerebral artery of sigmoid with metastasis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 9</u> , 19 <u>53</u> , to <u>Mar 26</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Mar 26</u> , 19 <u>53</u> , and that death occurred at <u>12 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Daniel F. Hogan</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>601 1/2 W 39th St, Apt 4</u>		23c. DATE SIGNED <u>3-27-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar 30 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>3-31-53</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Quirk & Robin Co 20 West Linwood</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed_____

Licensed Embalmer No. _____

P. O. Address_____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.